These two cases demonstrate the value of early operative interference in cases of suspected intestinal obstruction. The first case was brought to the surgeon when the patient was practically moribund, and of course no relief could be afforded. It is probable that the perfect recovery made by the second patient was largely due to the short interval which elapsed between the onset of the acute symptoms and the time of operation. The second case also shows the value of thorough inspection of the abdomen in cases of obstruction. I expected to find nothing but an occlusion of the bowel due to adhesions or bands. Had the real cause of the trouble been overlooked, the patient would necessarily have died.

In a very interesting article published in THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES for May, 1903, Dr. George Tully Vaughan cites twenty-one cases of volvulus of the entire mesentery. Seventeen of these were operated, with four recoveries, a mortality of about 76 per cent. This mortality, as stated by Dr. Vaughan, is due to three causes: First, the serious nature of "a condition which strangulates almost the entire small intestine, injures the sympathetic plexus, and perhaps produces a rapidly fatal toxæmia." Second, the delay in operating. Third, "the difficulty in recognizing the true condition in order to act intelligently, four of the operators cited confessing their inability to do so after opening the abdomen. The patients died without relief, the true condition being at last disclosed at the necropsy."

A SIMPLE METHOD FOR THE REDUCTION OF LUXATIONS OF THE HUMERUS.

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THOUGH the range of motion through movement of the humerus is great, the scapula normally admits of but little motion when the humerus is held in a fixed position. In luxations of the joint, however, the range of passive scapular motion is considerable, and it has been through studies of the possibilities due to this fact that the following methods have been evolved. They are, of course, susceptible to various modifications, according to the dexterity of the surgeon. The studies have extended over a period of four years' time, and include fifteen cases of the author's and nine cases which were referred to her; this number comprising only such cases as were uncomplicated by fracture of the scapula or clavicle, or of the necks of the humerus.

I. This method is applicable to subspinous dislocations, as well as to downward and forward luxations.

The surgeon stands behind the patient, who may sit or stand, as is convenient. In performing the manipulations the writer uses the hand corresponding to the side upon which the lesion exists.

The hand of the operator is partially closed, the thumb extended, and the wrist pronated. The ball of the thumb is placed below, against, and parallel to the lower margin of the scapula on the axillary border, just external to the inferior angle.

Firm pressure is exerted, and the wrist is slowly and steadily supinated, pressure upward and inward being exerted at the same time. This manipulation, if properly performed, pushes the lower angle of the scapula upward and toward the median line, depressing the lower lip of the glenoid cavity, and usually results in the prompt reduction of any variety of humeral dislocation.

In the subspinous variety, should reduction not occur, and a repetition of the manipulations bring no better result, pressure with the other thumb upon the head of the dislocated humerus, in the direction of the long axis of the bone, should be added, inserting the digit as deeply upon the head as is possible.

II. In subcoracoid or subglenoid dislocations, the operator stands behind the patient, as before, and places his hands on the patient's shoulders, with the palm of the hand at the base of the ring finger resting upon the acromion process of the scapula, the ball of the finger being placed below the clavicle. The ball of the middle finger is placed just above the clavicle, and that of the thumb beneath the spine of the scapula as far toward the inner end of the spine as is compatible with stability of position. The fingers should be slightly flexed, but not enough so as to interfere with firm pressure on the acromion process, nor so much so as to substitute the tips for the balls of the digits. The elbows should be extended. Quick but steady pressure should then be exerted in a downward, inward, and backward direction, considerable force being used.

This method has proven prompt and efficacious, even in cases in which the parts were greatly swollen from contusions sustained at the time of injury.

The following advantages are claimed for both methods:

1. There is little risk of further damage, since a short lever is used instead of a long one.

2. In cases in which fractures of the humerus, or of the bones of the forearm are present, the surgeon is enabled to effect reduction in a manner which does not necessitate the handling of the limb.

3. The patient does not suffer any great amount of pain during the procedure.

4. The patient is apt to be docile, since he does not expect reduction to be effected from the rear, and without manipulation of the arm.

Under the second method, if the patient offers resistance, he ordinarily starts forward, or, if sitting, he attempts to rise, thus assisting the surgeon.